



A High Performance Health System in Kansas: Learning from Other State Strategies and Private Sector Trends

Kansas Health Policy Authority Board Retreat
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Kansas: 23rd Healthiest State in the U.S. Why Not #1?

Strengths:

- **Relatively Low rate of uninsured**
- **Low prevalence of smoking**
- **Few limited activity days**



Progress:

- **Since 2004, incidence of infectious disease declined 1.9 cases per 100,000 population**
- **Since 1990, prevalence of smoking has decreased by 10.4%**

Challenges:

- **Since 2004, children in poverty has increase from 14.5 to 15.6 for those under 18**
- **Significant health disparities within the state, e.g. infant mortality rate for non-Hispanic blacks more than two times the rate for non-Hispanic blacks**

Source: United Health Foundation, *America's Health Rankings: A Call to Action for People and Their Communities*, 2005.



Presentation Overview

- What is needed for a high performance health system?
- State strategies to achieve better performance
- Private sector benefits trends
- Challenge to Authority



Dimensions of a High Performance Health System

- Long and healthy lives
- Getting the right care
- Coordinated care over time
- Safe care
- Patient-centered care/service excellence
- Efficient, high-value care
- Affordable care
- Universal participation
- Equitable care
- System has the capacity to improve

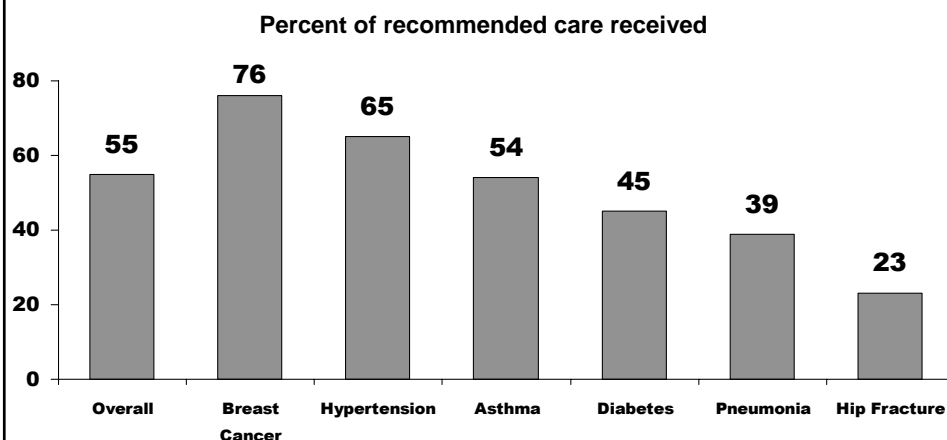
****Is the U.S. the benchmark for any of these?
Can Kansas be?**



Getting the Right Care



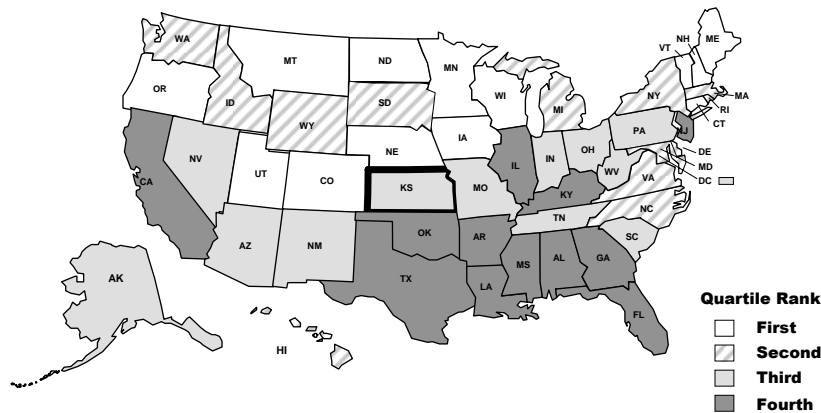
U.S. Adults Receive Half of Recommended Care, and Quality Varies Significantly by Medical Condition



Source: E. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *The New England Journal of Medicine* (June 26, 2003): 2635–2645.



Provision of Appropriate Care Performance on Medicare Quality Indicators 2000–2001



Note: State ranking based on 22 Medicare performance measures.

Source: S.F. Jencks, E.D. Huff, and T. Cuerdon, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (Jan. 15, 2003): 305–312.



Patient-Centered Care/ Service Excellence



Opportunities Exist for Enhanced Doctor–Patient Communication and Interactions

Percent saying doctor:	AUS	CAN	NZ	UK	US
Always listens carefully	71	66	74	68	58
Always explains things so you can understand	73	70	73	69	58
Always spends enough time with you	63	55	66	58	44

Source: 2004 Commonwealth Fund International Health Policy Survey.

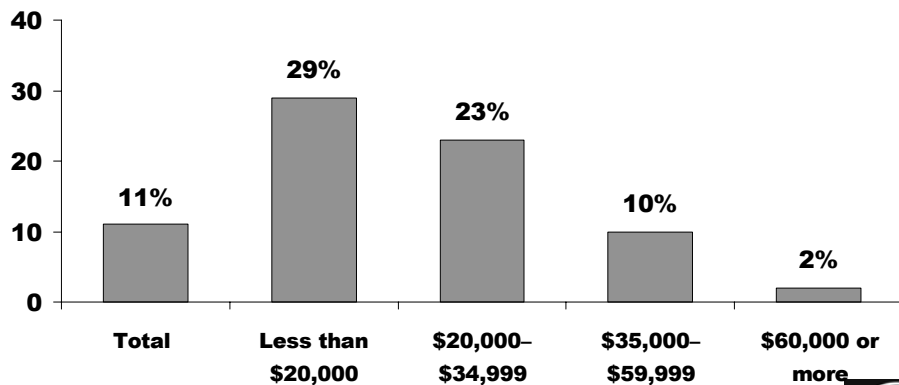


Affordable Care



Privately Insured Adults with Low and Moderate Incomes Spend High Share of Income (5% or more) on Out-of-Pocket Costs

Percent spending 5% or more on out-of-pocket costs



Note: Income groups based on 2002 household income.

Source: Collins, Doty, Davis et al., The Affordability Crisis in U.S. Health Care: Findings from The Commonwealth Fund Biennial Health Insurance Survey, The Commonwealth Fund, March 2004.



Universal Participation



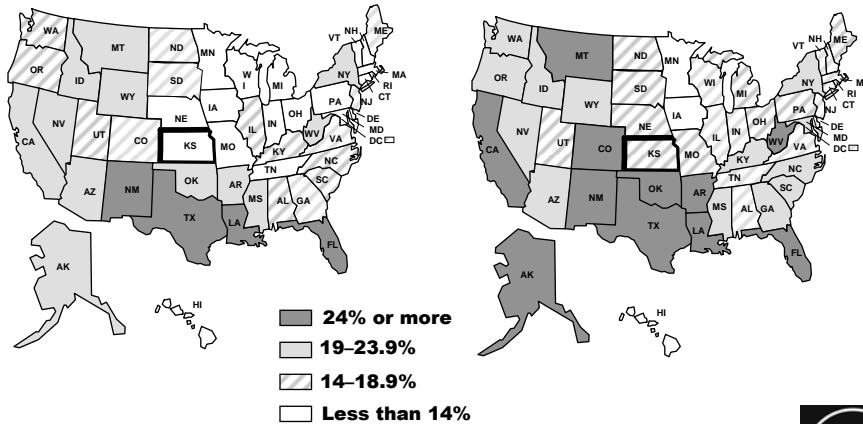
"Bad news, Zoltron, they don't have universal health insurance."



Percent of Adults 19-64 Uninsured by State

1999-2000

2003-2004



Source: Two-year averages 1999-2000 and 2003-2004 from the Census Bureau's March Current Population Survey (CPS: Annual Social and Economic Supplements). Estimates by EBRI.

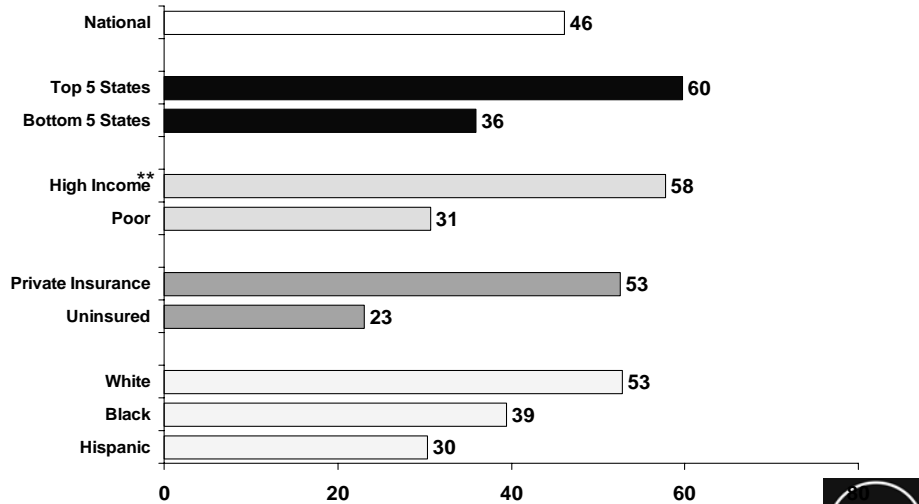


Equitable Care



Medical Home for Children, 2003

Percent of children who have a medical home*



*Children who have a primary care provider who provides accessible, coordinated and preventive care.

** High income refers to household incomes $\geq 400\%$ of Federal poverty level; and Poor, $<100\%$ of poverty level.

Source: 2003 National Survey of Children's Health; Retrieved from www.nschdata.org



Improving Performance is Multi-Dimensional

- Improving access, quality and lowering costs are inter-related goals
 - Medical care highly valued.
 - prevent untimely illness/death; help reach full potential
 - treat acute illness; manage chronic disease
 - improve quality of life and productivity
 - Rising costs putting coverage and access at risk. Financial stress for individuals and families, business, public programs
 - Critical to examine quality and cost together (= efficiency): eliminating errors, overuse, rework, inefficient processes and duplication will increase quality and decrease costs. True that some quality enhancements will be costly. Need to assess from systems perspective.



State Strategies: Potential Laboratories for Change

- To date, most state-wide initiatives focused on coverage/access. Some shared strategies emerging.
- A few states looking to broad access, quality and cost public/private initiatives
 - Maine
 - Minnesota
 - Rhode Island
 - Washington
- Other states mixing state and regional initiatives



State Strategies to Expand Coverage

- Expand public programs
- Provide financial assistance to workers and employers to afford coverage
- Promote public/private partnerships with employers
- Pool purchasing power to make coverage more affordable
- Promote new benefit designs to make coverage more affordable
- Employer mandates



Expand Public Programs

- Enroll those eligible but not enrolled
- Raise income threshold for eligibility
- Allow buy-ins for workers
- Leverage federal matching funds



Provide Financial Assistance to Workers and Employers to Afford Coverage

- Tax Credits



Montana Small Business
Health Care Affordability Act

- Other Subsidies



Oklahoma Employer/Employee
Partnership for Insurance Coverage

- Reinsurance



Promote Public-Private Partnerships with Employers

- Subsidize private insurance for Medicaid/ SCHIP eligibles



- For small businesses, use state buying power to negotiate provider rates, same as states' rates



Pool Purchasing Power to Make Coverage More Affordable

- For State employees, consolidated or joint action purchasing



Minnesota Public Employee Insurance Program (PEIP)

- Promote association health plans (AHPs) or alliances
 - Arkansas: Small Employer Health Insurance Purchasing Group Act of 2001 allowed for the formation of health insurance purchasing groups for the purpose of buying health insurance.
 - Wisconsin: 2003 legislation created five regional health care purchasing alliances to bring farmers and small businesses into one pool per region



New Benefit Designs May Lower Premiums; Longer Term Effects Unknown

- Health savings accounts (HSA)
 - Most states have passed laws making HSA contributions tax free and have modified regulations to conform with federal law
 - Short term savings from high deductible health plans have differential impacts depending on income
- Limited Benefits
 - Georgia, Kentucky: passed 2005 legislation allowing carriers to develop new products without many of the state mandated benefits
 - Most states see little interest by consumers
 - Texas: 17,000 enrolled in new Consumer Choice plans, with limited benefits
- Modified benefits in public programs
 - Utah Primary Health Care is testing a primary/ preventive care benefit to reach more of the uninsured
 - California maintaining recent coverage expansions by focus on improved management of care for seniors and disabled.
 - West Virginia, Florida, South Carolina and Kentucky all have Medicaid proposals that include some type of personal account



Employer Mandates

- Mandate employers to “pay or play”
 - Legislatures in 12 states introduced “pay or play” bills in 2005
 - Currently Hawaii is the only state with an employer mandate law in effect
 - Maryland passed, and others considering “Wal-Mart bill”: employers with 10,000 employees must spend 8% of payroll on health benefits (6% if non-profit)



State Strategies to Improve Quality and Efficiency

- Promote evidence-based medicine
- Promote effective chronic care management
- Encourage data transparency and reporting on performance
- Promote/practice value-based purchasing
- Promote the use of health information technology
- Promote wellness and healthy living




Several States Trying Comprehensive Approach

- Washington State Health Care Authority
 - Developing public-private partnerships to expand coverage, improve quality
 - Leads and coordinates state efforts in initiatives focused on evidence-based medicine, chronic care management, data transparency, HIT and wellness
- Minnesota Smart-Buy
 - Efforts include initiative to lower costs by improved quality, safety and reduced administrative costs:
 - Adopt uniform methods for measuring quality, performance and outcomes and use in purchasing decisions. Standard reporting forms.
 - Reward “best in class” certification to identify health care providers achieving certain levels of expertise, experience, proficiency and results.
 - Empower consumers with easy access to information about costs and quality.
 - Encourage efficiencies and quality improvements by supporting development and/or requiring adoption of new technologies.



Evidence-Based Medicine

- Rationale: Systematic assessment of best available scientific and medical evidence and timely application of this evidence should inform coverage and medical necessity decisions
- E.g.,  Puget Sound HEALTH ALLIANCE
 - One of major goals to promote evidence-based throughout the King County in Washington
- E.g., Oregon Health Plan Condition/Treatment Pairs
 - Evidence used to update list of condition/treatment pairs covered under Medicaid



Effective Chronic Care Management

- Rationale: More than three-quarters of current Medicaid spending devoted to people with chronic conditions. Many states are pursuing efficiencies through various types of "care management" strategies for high-cost individuals. These services can be provided directly or contracted out to specialized vendors.
- E.g., CoverColorado, Colorado's high risk pool
 - Introduced advanced care management strategies into CoverColorado
 - Results: \$2.3 million in direct savings associated with the care-management interventions from May 2002 to September 2003
 - Joined with high risk pools from KS, WA, and OK to compare different care management strategies
- E.g., Community Care of North Carolina, care management for Medicaid
 - Results: Targeting frequent ED users resulted in \$10.4 million in savings for FY 2001–2002. Asthma and diabetes care-management programs saved \$3.3 million and \$2.1 million, 2000–2002.

Source: Stretching State Health Care Dollars: Targeted Care Management to Enhance Cost-Effectiveness
Sharon Silow-Carroll, M.B.A., M.S.W., and Tanya Alteras, M.P.P., The Commonwealth Fund,
October 2004



Data Transparency and Performance Reporting

- Rationale: Providing a more transparent, rational market for health care could reduce cost pressures, correct quality defects, and reverse decreases in consumer confidence that jeopardize the current system
- E.g. Maryland Health Care Commission
 - Releases annual state sponsored HMO performance guides, detailing how state commercial HMOS perform in terms of access and service, keeping people healthy and caring for the sick, with a focus on patients with chronic conditions
- E.g., Pennsylvania Health Care Cost Containment Council (PHC4)
 - Publicly reports patient outcomes on almost 80 treatment categories for physicians, hospitals and managed care plans



Value-Based Purchasing/P4P

- Rationale: State can improve quality and efficiency by building performance standards into health plan contracts and developing pay for performance programs for state employees and covered populations.
- E.g., New York State's Medicaid Incentive Program
 - Offers financial and other incentives to Medicaid managed care programs that perform well on a number of measures
- E.g., Group Insurance Commission (GIC) of Massachusetts (provides insurance to 250,000 state health workers and their families)
 - Starting in July 2006, workers will be charged lower out-of-pocket costs when they use high-quality physicians and hospitals



Health Information Technology

- Rationale: Health information technology (HIT) can help to reduce costs, increase efficiency and safety
- E.g., Rhode Island Quality Institute
 - Rhode Island Quality Institute has partnered with SureScripts, a collaborative effort between independent and chain pharmacies across the nation to implement state-wide electronic connectivity between all retail pharmacies and all prescribers in the state
- E.g., Tennessee Community Connections Program
 - Partnership between state and BlueCross BlueShield of Tennessee will bring patient-centered community health records to all TennCare (Medicaid managed care plan) members. Records will allow multiple providers treating the same patient to view the patient's medical record via the internet



Wellness and Healthy Living

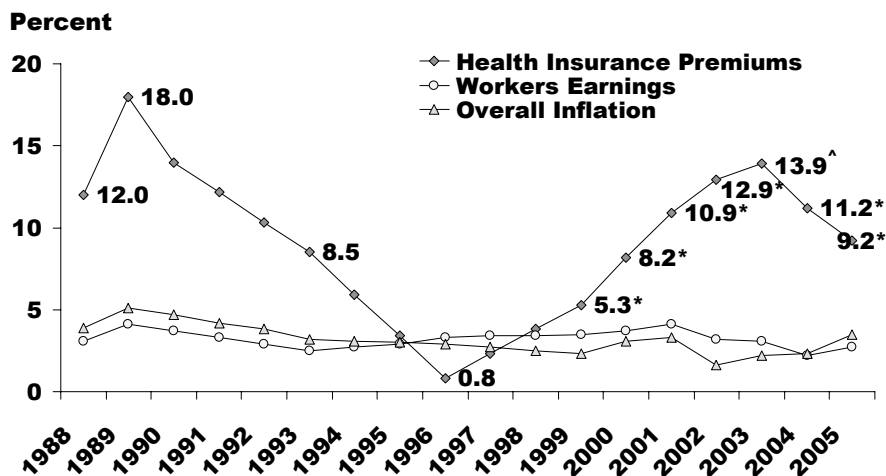
- Rationale: By enhancing overall health and wellness for employees, retirees and dependents, create a healthy, productive workforce and positively impact the cost of health care
- E.g., Arkansas BMI Project
 - Arkansas legislation has mandated BMI measurement in Arkansas public schools in an effort to curb childhood obesity in the state
- E.g., Florida Medicaid Program
 - Proposal to redesign Medicaid includes Enhanced Benefits Accounts, in which state will deposit funds for healthy behaviors; Funds to be used for health-care related expenses



Trends in Private Insurance



Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2005



Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 2005;

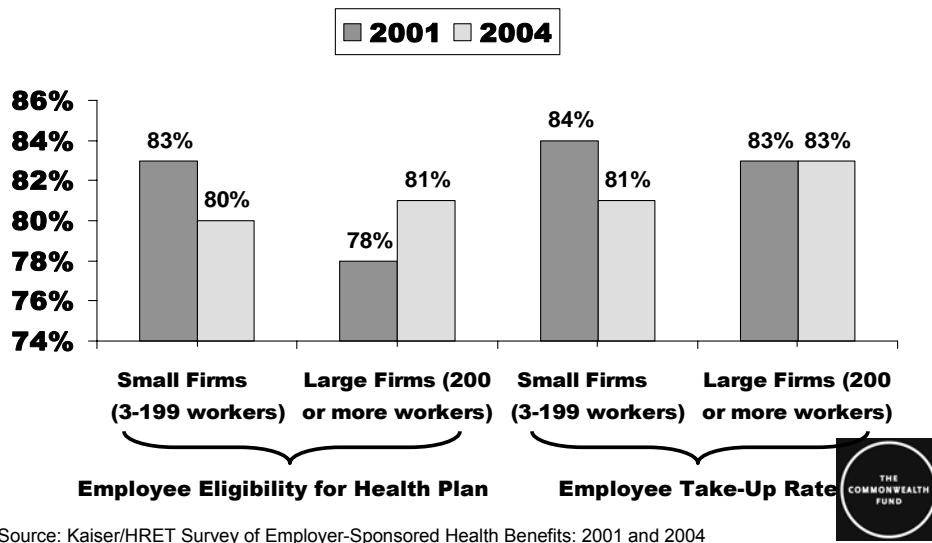
*Estimate is statistically different from the previous year shown at $p < 0.05$

^ Estimate is statistically different from the previous year shown at $p < 0.1$.

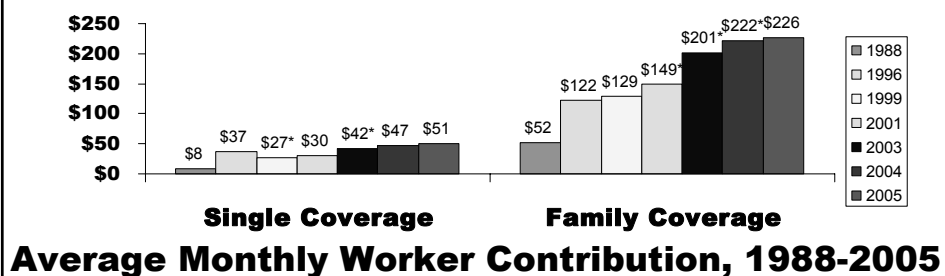
Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Historical estimates workers' earnings have been updated to reflect new industry classifications (NAICS).



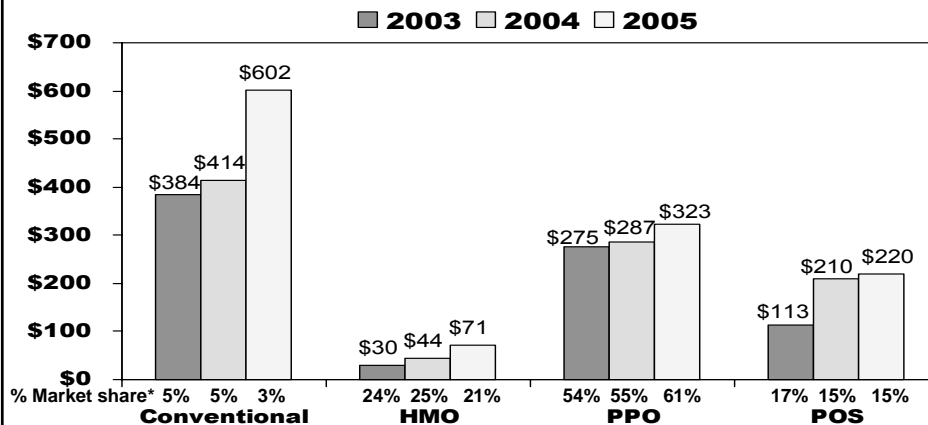
Employee Eligibility and Take-Up of Health Benefits, 1997 and 2002



Average Monthly Worker Contribution, 1988-2005



Average Annual Deductible for Single Coverage, by Plan Type, 1999-2005



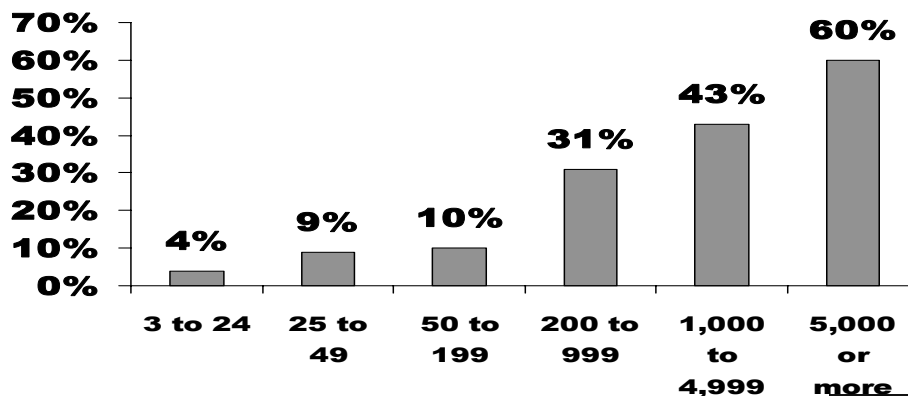
Note: Average deductibles for PPO and POS plans are for in-network services. Averages include covered workers who do not have a deductible. If covered workers with no deductibles for single coverage for 2005 are as follows: conventional - \$671; HMO - \$568; PPO - \$455; POS - \$495.

* Percentage beneath s-axis gives percent market share of each plan type in the given year.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2005



Percentage of Employers Offering Retiree Health Benefits*, by Number of Employees, 2004

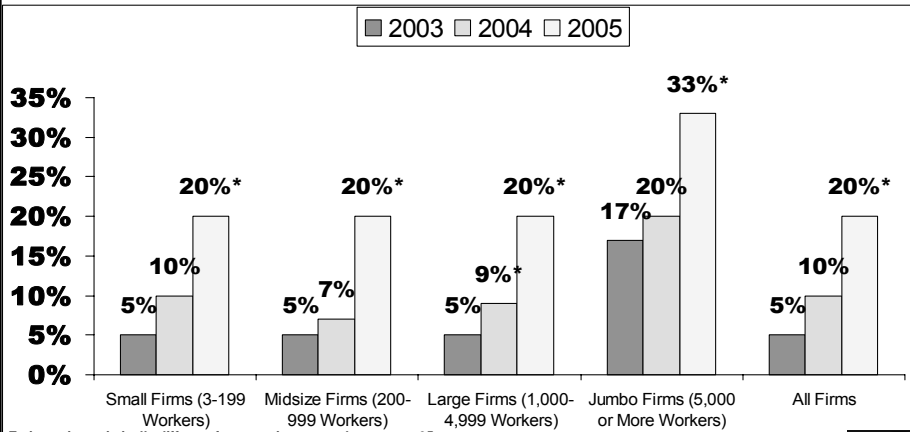


*Among firms that offer health benefits to active workers

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 2004



Percentage of Firms That Offer Employees a High-Deductible Health Plan, by Firm Size, 2003-2005



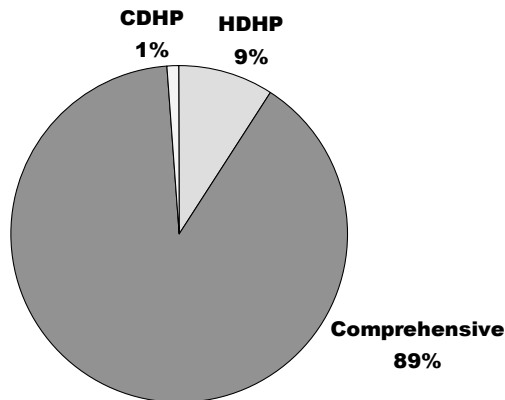
Estimate is statistically different from previous year shown at $p < .05$

High-deductible health plan (HDHP): A plan with an annual deductible of at least \$1,000 for single coverage and \$2,000 for family coverage. In 2003 and 2004, the survey used a different definition and asked if firms offered a health plan with a deductible of more than \$1,000 for single coverage. The survey did not specify a minimum deductible for family coverage. The prevalence shown is for all HDHPs, regardless of whether they are offered with an HRA, are HAS qualified, or neither

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2003-2005.



Distribution of Covered Lives by Private Health Insurance, by Type of Health Plan



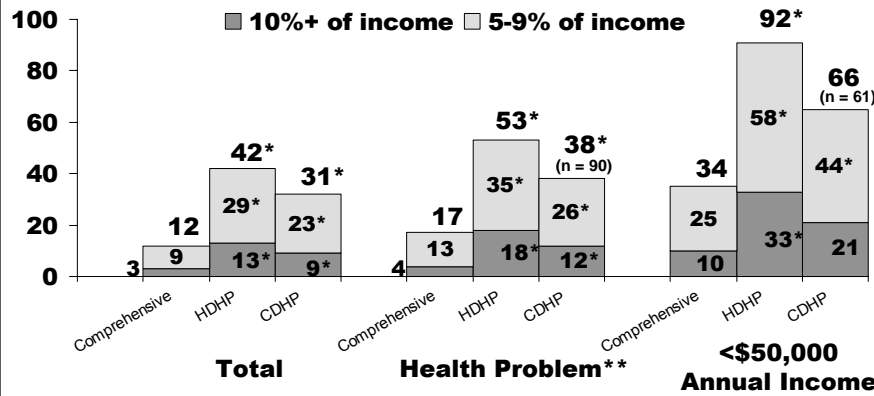
Note: Comprehensive = plan w/ no deductible or <\$1000 (ind), <\$2000 (fam); HDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), no account; CDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), w/ account.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.



Percent of Income Spent Annually on Out-of-Pocket Medical Expenses, Including Premiums

Percent of adults 21-64 spending $\geq 5\%$ of income



Note: Comprehensive = plan w/ no deductible or $\leq \$1000$ (ind), $\leq \$2000$ (fam); HDHP = plan w/ deductible $\$1000+$ (ind), $\$2000+$ (fam), no account; CDHP = plan w/ deductible $\$1000+$ (ind), $\$2000+$ (fam), w/ account.

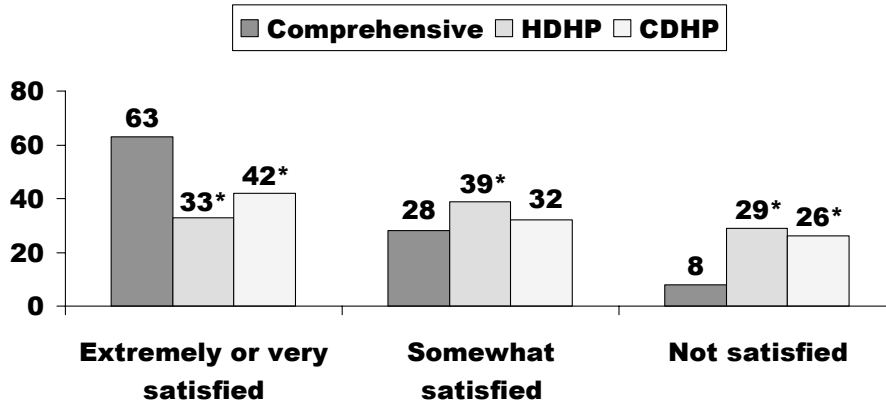
*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

**Health problem defined as fair or poor health or one of eight chronic health conditions.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.



Overall Satisfaction with Health Plan, by Type of Health Plan



Note: Comprehensive = plan w/ no deductible or $\leq \$1000$ (ind), $\leq \$2000$ (fam); HDHP = plan w/ deductible $\$1000+$ (ind), $\$2000+$ (fam), no account; CDHP = plan w/ deductible $\$1000+$ (ind), $\$2000+$ (fam), w/ account.

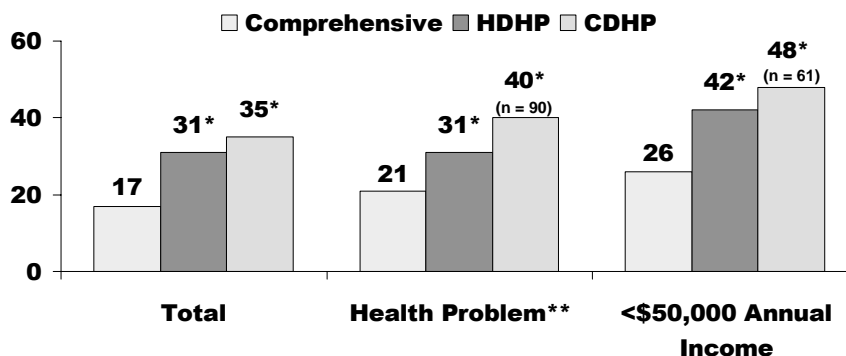
*Difference between HDHP/CDHP and Comprehensive is statistically significant at $p \leq 0.05$ or better.

Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.



Percent of Adults Who Have Delayed or Avoided Getting Health Care Due to Cost

Percent of adults 21-64



Note: Comprehensive = plan w/ no deductible or <\$1000 (ind), <\$2000 (fam); HDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), no account; CDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), w/ account.

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Source: EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2005.



Availability and Use of Quality and Cost Information Provided by Health Plan

	Comprehensive	HDHP/CDHP
Health plan provides information on quality of care provided by:		
Doctors	14%	16%
Hospitals	14	15
Health plan provides information on cost of care provided by:		
Doctors	16	12
Hospitals	15	12
Of those whose plans provide info on quality, how many tried to use it for:		
Doctors	42	54
Hospitals	25	45*
Of those whose plans provide info on cost, how many tried to use it for:		
Doctors	15	36* (n = 76)
Hospitals	14	32* (n = 76)

Note: Comprehensive = plan w/ no deductible or <\$1000 (ind), <\$2000 (fam); HDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), no account; CDHP = plan w/ deductible \$1000+ (ind), \$2000+ (fam), w/ account.

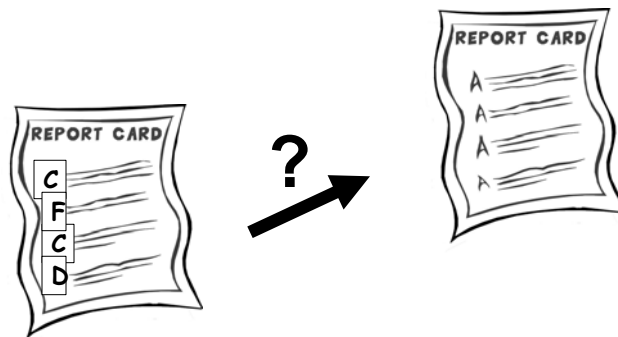
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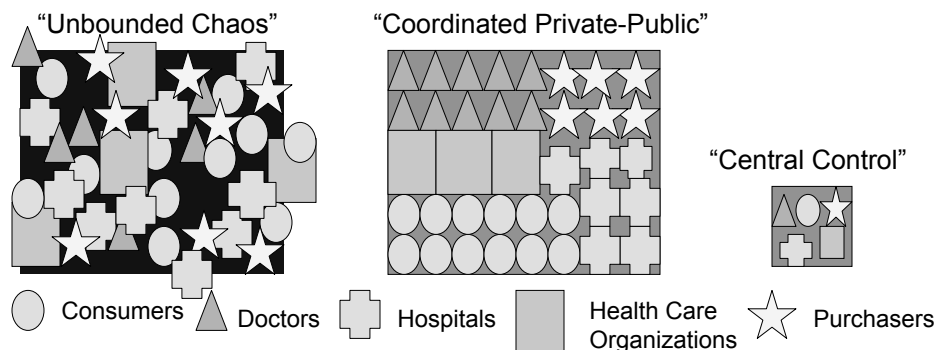


Challenge to the Kansas Health Policy Authority Board

- How can you move Kansas towards higher performance? How can Kansas become a benchmark for one or more of the dimensions of high performance?



Health System Options for Kansas and the United States



How can the Kansas health system become coordinated; and what would need to be coordinated?



Coordination Needs To Be A Team Effort

- **Health Policy Authority and State Agencies**
- **Federal Government**
- **General public**
- **Employers**
- **Insurers**
- **Providers**
- **Pharmaceutical companies**
- **Accreditors**



Fort Hunt U-15 Lacrosse Team

(Jesse Gauthier, #4)



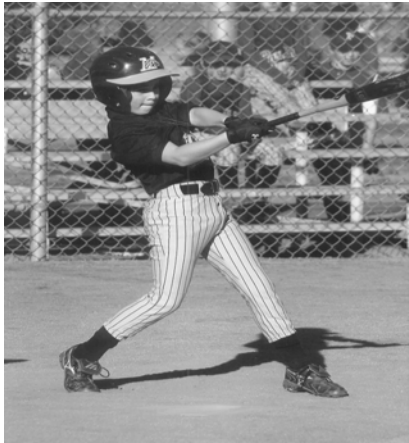
Start Today

Pick one or more dimensions of performance and lead

- **Coverage?**
- **Quality?**
- **Safety?**
- **Affordability/Efficiency?**



The Kansas Health Policy Authority has the opportunity to hit one out of the park!!



Adam Gauthier, future MLB star



Commonwealth Fund Commission on a High Performance Health System

- **GOAL:** Move the U.S. toward a higher-performing health care system that achieves better access, improved quality, and greater efficiency, with particular focus on the most vulnerable due to income, race/ethnicity, health, or age.
- **STRUCTURE:** 18 members; James Mongan, MD, chair; 3 meetings per year (2 thus far)
- **CHALLENGE:** The Commission must focus on the “substantive few” critical issues that can accelerate performance improvement in the U.S. health care system. It will need to seek and recommend innovative ways to get these issues onto the public and private policy agendas.
- **INITIAL PRODUCTS:** Chartbook on current performance (www.cmwf.org). Framework for a high performance health system Annual performance scorecard. Briefs on critical national policy issues (*available 2/06*).



Acknowledgements



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